Michigan Department of Community Health
Bureau of Health Systems
Division of Nursing Home Monitoring

FACILITY INFORMATION SHEET

SECTION 1: FACILITY INFORMATION

1. Facility Name:	2. Facility Number:
3. Facility Phone Number:	4. Facility Fax Number:

SECTION 2: ADMINISTRATOR INFORMATION

1. Administrator Name:	2. License Number:
3. E-mail Address:	4. Emergency Contact Person & Phone Number

SECTION 3: DIRECTOR OF NURSING

1. Director of Nursing Name:	2. License Number:
3. D.O.N. E-mail Address:	

SECTION 4: FISCAL INTERMEDIARY INFORMATION

1. Fiscal Intermediary (F.I.):	2. F.I. Carrier Number:
3. Address (City, State, Zip Code)	

SECTION 5: CERTIFIED BEDS:

Medicare SNF 18: _____

Medicaid NF 19: _____

Medicare/Medicaid 18/19: _____

Total Certified Beds: _____

Licensed only Beds: _____

Total Facility Beds: _____

Authority P.A. 368 of 1978 as amended
Completion: Mandatory
BHS-NHM-271(8/06)

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SECTION 6: OWNERSHIP (legal entity which directly owns the facility)

1. Company/Owner Legal Name:	
2. Street Address:	3. City, State, Zip Code
4. Company Phone Number:	5. Federal Tax ID Number: ☐☐-☐☐☐☐☐☐☐
6. Primary Owner or Contact Name:	
7. Corporation officers/directors/trustees: (attach additional pages if necessary) Name Address _____ _____ _____	
8. Parent Organization Name:	
Address:	City, State, Zip:

SECTION 7: AIR CONDITION

Is the facility air conditioned? ☐Yes ☐ No	If yes, is it ☐ Fully ☐ Partially air conditioned Please attach a facility map indicating which areas are affected.

SECTION 8: CERTIFICATION BY APPLICANT

- This form must be completed and returned to the survey staff prior to the end of the survey.
- The Administrator certifies that the information provided is true, complete and accurate to the best of his/her knowledge.

Administrator Signature:	Date: